

Be it enacted by the People of the State of Montana:

NEW SECTION. Section 1. Short title. [Sections 1 through 9] may be cited as the "Healthy Montana Kids Plan Act".

NEW SECTION. Section 2. Purpose. The purposes of [sections 1 through 9] are to:

- (1) create the healthy Montana kids plan, which offers health coverage to uninsured children by increasing eligibility for the children's health insurance program and the Montana medicaid program and by helping families cover their children under employer-sponsored plans;
- (2) provide for active enrollment of children in the plan; and
- (3) fully utilize available federal funds to provide health coverage for children.

NEW SECTION. Section 3. Definitions. For purposes of [sections 1 through 9], the following definitions apply:

- (1) "Comprehensive" means health insurance having benefits at least as extensive as those provided under the children's health insurance program.
- (2) "Department" means the department of public health and human services provided for in 2-15-2201.
- (3) "Enrollee" means a child who is enrolled or in the process of being enrolled in the plan, including children already enrolled in the programs described in [section 4(2)].
- (4)(a) "Enrollment partner" means an organization or individual approved by the department to assist in enrolling eligible children in the plan.
 - (b) An enrollment partner may be but is not limited to:
 - (i) a licensed health care provider;
 - (ii) a school;
 - (iii) a community-based organization; or
 - (iv) a government agency.
- (5) "Health coverage" means a program administered by the department or a disability insurance plan, referred to in 33-1-207(1)(b), that provides public or private health insurance for children.
- (6) "Income" has the meaning provided in 15-30-171(9)(a). *[[(9) (a) "Income" means, except as provided in subsection (9)(b), federal adjusted gross income, without regard to loss, as that quantity is defined in the Internal Revenue Code of the United States, plus all nontaxable income, including but not limited to:
 - (i) the amount of any pension or annuity, including Railroad Retirement Act benefits and veterans' disability benefits;
 - (ii) the amount of capital gains excluded from adjusted gross income;
 - (iii) alimony;
 - (iv) support money;
 - (v) nontaxable strike benefits;
 - (vi) cash public assistance and relief;
 - (vii) interest on federal, state, county, and municipal bonds; and
 - (viii) all payments received under federal social security except social security income paid directly to a nursing home.]]*

(7) "Plan" means the healthy Montana kids plan established in [section 4].

(8) "Premium" means the amount of money charged to provide coverage under a public or private health coverage plan.

(9) "Presumptive eligibility" has the meaning provided in 42 CFR 457.355.

NEW SECTION. Section 4. Healthy Montana kids plan. (1) There is a healthy Montana kids plan that provides comprehensive health coverage to uninsured children who are residents of the state.

(2) The plan includes and coordinates access to health coverage for enrollees in the children's health insurance program and the Montana medicaid program.

(3) The department shall administer the plan.

(4) To the extent permitted by federal law, the department shall use the name of the plan on documents associated with programs described in subsection (2), including but not limited to advertising, brochures, applications, and membership cards.

(5) State funding of the plan is contingent upon the availability of federal matching funds through the children's health insurance program or the Montana medicaid program.

NEW SECTION. Section 5. Rulemaking -- active enrollment -- plan coordination. (1) The department shall adopt rules necessary to implement [sections 1 through 9], including plan administration, plan enrollment, outreach efforts, and standards of performance to allow enrollment partners to assist in enrolling children in the plan or other health coverage plans administered by the department.

(2) The rules must:

(a) establish a process for identifying and approving enrollment partners;

(b) create and define an active enrollment process;

(c) promote seamless movement between programs described in [section 4(2)];

(d) promote accessible enrollment through enrollment partners;

(e) provide, to the extent permitted by law, a single point of access in the department for plan members;

(f) define income for purposes of determining eligibility for children's health coverage programs within the plan;

(g) provide for presumptive eligibility; and

(h) encourage enrollment partners to actively enroll as many eligible, uninsured children as possible in the plan or in an employer-sponsored plan as described in [section 6].

(3) The rules may include the development of enrollment partner training, technical assistance programs, and performance measures.

(4) The rules may provide for an exemption from the active enrollment process based upon an individual showing of:

(a) religious conviction;

(b) private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), obtained by the parents for the child from a private group or individual health insurance issuer or under a self-funded employer health plan; or

(c) other compelling circumstances.

(5) The rules governing eligibility and premium assistance must be consistent with [sections 1 through 9]. Rules may include but are not limited to financial standards and criteria for income, nonfinancial criteria, family responsibility, residency, the application process, termination of eligibility, definition of terms, and confidentiality of applicant and recipient information.

NEW SECTION. Section 6. Enrollment in employer-sponsored plans. The department may:

(1) provide premium assistance to families who have access to one or more employer-sponsored comprehensive group health insurance plans in order to provide coverage for eligible children. The premium assistance may not exceed the cost of coverage for that child under the plan.

(2) provide assistance to employers who establish a premium-only health benefits plan under section 125 of the Internal Revenue Code, 26 U.S.C. 125, for the purpose of enrolling children in such a plan and allowing their families to pay any premium with pretax dollars.

NEW SECTION. Section 7. Federal financial participation. The department shall request any necessary state plan amendments or waivers of federal requirements in order to allow receipt of the maximum available federal funds to facilitate implementation of [sections 1 through 9], subject to appropriation of necessary matching state funds.

NEW SECTION. Section 8. Exemption from resource test. An otherwise applicable eligibility resource test provided for in 53-6-113(6) and 53-6-131(7) does not apply to plan applicants.

NEW SECTION. Section 9. Special revenue account. (1) There is an account in the state special revenue fund to the credit of the department for the purposes provided in subsection (2). There must be paid into the account the amounts collected under 33-2-708(3)(b). Any interest or income derived from the account must be deposited in the account.

(2) Money in the account:

(a) is to be used solely to cover the number of additional enrollees in the plan that exceeds the number of enrollees as of [the effective date of this act], within the limits provided in 53-4-1004, 53-6-131, and [sections 1 through 9], and to cover the costs of enrollment, including premium assistance, under [section 6(1)], and to pay administrative costs associated with expanded eligibility, and to establish and maintain a reserve; and

(b) may be used only to match federal funds available under the children's health insurance program and the Montana medicaid program.

(3) The unexpended balance of an appropriation from the account must remain in the account and may be used only for the purposes stated in subsection (2).

(4) The special revenue account does not affect and is not exclusive of any other sources of funding for the programs described in [section 4(2)], including the special revenue account provided for in 53-4-1012.

(5) If the department determines that there is insufficient funding for the purposes of subsection (2), it may reduce eligibility requirements for participants in the children's health insurance program as provided in 53-4-1004(4).

Section 10. Section 33-2-708

"33-2-708. Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of \$1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, \$100;

(B) biennial renewal of license, \$50;

(C) lapsed license reinstatement fee, \$100;

(ii) resident insurance producer's license lapsed license reinstatement fee, \$100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

- (C) lapsed license reinstatement fee, \$200;
- (vii) resident and nonresident rental car entity producer's license:
- (A) application for original license, including issuance of license, if issued, \$100;
- (B) quarterly filing fee, \$25;
- (viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), \$50;
- (ix) 50 cents for each page for copies of documents on file in the commissioner's office.
- (c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.
- (2) (a) The commissioner shall charge a fee of \$75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than \$1,500 to a sponsoring organization submitting courses or programs for review in any biennium.
- (b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).
- (3) (a) ~~The Except as provided in subsection (3)(b),~~ the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.
- (b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for [section 9].
- (c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.
- (4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of \$10 will be refunded."

Section 11. Section 53-4-1004

"53-4-1004. (Temporary) Eligibility for program -- rulemaking. (1) To be considered eligible for the program, a child:

- (a) must be 18 years of age or younger;
- (b) must have a combined family income at or below ~~175%~~ 250% of the federal poverty level or at a lower level determined by the department of public health and human services as provided in subsection (4);
- (c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), for 3 months prior to enrollment in the program or since birth, whichever period is less;

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate or may limit the amount, scope, or duration of specific services provided. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 12. Section 53-6-131

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of public health and human services, in its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess of the applicable medical assistance limits.

(b) The person would be eligible for assistance under the program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under the program in subsection (1)(a).

(d) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs.

(e) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(d) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) has resources that are within the resource standards of the federal supplemental security income program.

(f) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

(g) The person is under 19 years of age and lives with a family having a combined income that does not exceed 185% of the federal poverty level. The Department may establish lower income levels to the extent necessary to maximize federal matching funds provided for in [section 4].

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program. Any otherwise applicable eligibility resource test prescribed by the department does not apply to enrollees in the healthy Montana kids plan provided for in [section 4].

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

(a) has income that does not exceed income standards as may be required by the Social Security Act; and

(b) has resources that do not exceed standards that the department determines reasonable for purposes of the program.

(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

(5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may grant eligibility for basic medicaid benefits as described in 53-6-101 to an individual receiving section 1931 medicaid benefits, as defined in 53-4-602, as the specified caretaker relative of a dependent child under the section 1931 medicaid program. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.

(6) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

(7) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

(8) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.

(9) A person described in subsection (7) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(10) Full medical assistance under the Montana medicaid program may be granted to an individual during the period in which the individual requires treatment of breast or cervical cancer, or both, or of a precancerous condition of the breast or cervix, if the individual:

(a) has been screened for breast and cervical cancer under the Montana breast and cervical health program funded by the centers for disease control and prevention program established under Title XV of the Public Health Service Act, 42 U.S.C. 300k, or in accordance with federal requirements;

(b) needs treatment for breast or cervical cancer, or both, or a precancerous condition of the breast or cervix;

(c) is not otherwise covered under creditable coverage, as provided by federal law or regulation;

(d) is not eligible for medical assistance under any mandatory categorically needy eligibility group; and

(e) has not attained 65 years of age."

NEW SECTION. Section 13. Codification instruction. [Sections 1 through 9] are intended to be codified as an integral part of Title 53, chapter 4, and the provisions of Title 53, chapter 4, apply to [sections 1 through 9].

NEW SECTION. Section 14. {standard} Contingent termination. (1) [Section 11], amending 53-4-1004, terminates on the date that the director of the department of public health and human services certifies to the governor that the federal government has terminated the program or that the federal funding for the program has been discontinued.

(2) The governor shall transmit a copy of the certification to the code commissioner.

(3) Any excess funds remaining upon the termination of the program must be transferred to the general fund.

New Section. Section 15. {standard} This act is effective upon approval by the electorate

Be it enacted by the People of the State of Montana:

NEW SECTION. Section 1. Short title. [Sections 1 through 9] may be cited as the "Healthy Montana Kids Plan Act".

NEW SECTION. Section 2. Purpose. The purposes of [sections 1 through 9] are to:

- (1) create the healthy Montana kids plan, which offers health coverage to uninsured children by increasing eligibility for the children's health insurance program and the Montana medicaid program and by helping families cover their children under employer-sponsored plans;
- (2) provide for active enrollment of children in the plan; and
- (3) fully utilize available federal funds to provide health coverage for children.

NEW SECTION. Section 3. Definitions. For purposes of [sections 1 through 9], the following definitions apply:

- (1) "Comprehensive" means health insurance having benefits at least as extensive as those provided under the children's health insurance program.
- (2) "Department" means the department of public health and human services provided for in 2-15-2201.
- (3) "Enrollee" means a child who is enrolled or in the process of being enrolled in the plan, including children already enrolled in the programs described in [section 4(2)].
- (4)(a) "Enrollment partner" means an organization or individual approved by the department to assist in enrolling eligible children in the plan.

(b) An enrollment partner may be but is not limited to:

- (i) a licensed health care provider;
- (ii) a school;
- (iii) a community-based organization; or
- (iv) a government agency.

(5) "Health coverage" means a program administered by the department or a disability insurance plan, referred to in 33-1-207(1)(b), that provides public or private health insurance for children.

(6) "Income" has the meaning provided in 15-30-171(9)(a). *[[(9) (a) "Income" means, except as provided in subsection (9)(b), federal adjusted gross income, without regard to loss, as that quantity is defined in the Internal Revenue Code of the United States, plus all nontaxable income, including but not limited to:*

(i) the amount of any pension or annuity, including Railroad Retirement Act benefits and veterans' disability benefits;

(ii) the amount of capital gains excluded from adjusted gross income;

(iii) alimony;

(iv) support money;

(v) nontaxable strike benefits;

(vi) cash public assistance and relief;

(vii) interest on federal, state, county, and municipal bonds; and

(viii) all payments received under federal social security except social security income paid directly to a nursing home.]]

(7) "Plan" means the healthy Montana kids plan established in [section 4].

(8) "Premium" means the amount of money charged to provide coverage under a public or private health coverage plan.

(9) "Presumptive eligibility" has the meaning provided in 42 CFR 457.355.

NEW SECTION. Section 4. Healthy Montana kids plan. (1) There is a healthy Montana kids plan that provides comprehensive health coverage to uninsured children who are residents of the state.

(2) The plan includes and coordinates access to health coverage for enrollees in the children's health insurance program and the Montana medicaid program.

(3) The department shall administer the plan.

(4) To the extent permitted by federal law, the department shall use the name of the plan on documents associated with programs described in subsection (2), including but not limited to advertising, brochures, applications, and membership cards.

(5) State funding of the plan is contingent upon the availability of federal matching funds through the children's health insurance program or the Montana medicaid program.

NEW SECTION. Section 5. Rulemaking -- active enrollment -- plan coordination. (1) The department shall adopt rules necessary to implement [sections 1 through 9], including plan administration, plan enrollment, outreach efforts, and standards of performance to allow enrollment partners to assist in enrolling children in the plan or other health coverage plans administered by the department.

(2) The rules must:

(a) establish a process for identifying and approving enrollment partners;

(b) create and define an active enrollment process;

(c) promote seamless movement between programs described in [section 4(2)];

(d) promote accessible enrollment through enrollment partners;

(e) provide, to the extent permitted by law, a single point of access in the department for plan members;

(f) define income for purposes of determining eligibility for children's health coverage programs within the plan;

(g) provide for presumptive eligibility; and

(h) encourage enrollment partners to actively enroll as many eligible, uninsured children as possible in the plan or in an employer-sponsored plan as described in [section 6].

(3) The rules may include the development of enrollment partner training, technical assistance programs, and performance measures.

(4) The rules may provide for an exemption from the active enrollment process based upon an individual showing of:

(a) religious conviction;

(b) private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), obtained by the parents for the child from a private group or individual health insurance issuer or under a self-funded employer health plan; or

(c) other compelling circumstances.

(5) The rules governing eligibility and premium assistance must be consistent with [sections 1 through 9]. Rules may include but are not limited to financial standards and criteria for income, nonfinancial criteria, family responsibility, residency, the application process, termination of eligibility, definition of terms, and confidentiality of applicant and recipient information.

NEW SECTION. Section 6. Enrollment in employer-sponsored plans. The department may:

(1) provide premium assistance to families who have access to one or more employer-sponsored comprehensive group health insurance plans in order to provide coverage for eligible children. The premium assistance may not exceed the cost of coverage for that child under the plan.

(2) provide assistance to employers who establish a premium-only health benefits plan under section 125 of the Internal Revenue Code, 26 U.S.C. 125, for the purpose of enrolling children in such a plan and allowing their families to pay any premium with pretax dollars.

NEW SECTION. Section 7. Federal financial participation. The department shall request any necessary state plan amendments or waivers of federal requirements in order to allow receipt of the maximum available federal funds to facilitate implementation of [sections 1 through 9], subject to appropriation of necessary matching state funds.

NEW SECTION. Section 8. Exemption from resource test. An otherwise applicable eligibility resource test provided for in 53-6-113(6) and 53-6-131(7) does not apply to plan applicants.

NEW SECTION. Section 9. Special revenue account. (1) There is an account in the state special revenue fund to the credit of the department for the purposes provided in subsection (2). There must be paid into the account the amounts collected under 33-2-708(3)(b). Any interest or income derived from the account must be deposited in the account.

(2) Money in the account:

(a) is to be used solely to cover the number of additional enrollees in the plan that exceeds the number of enrollees as of [the effective date of this act], within the limits provided in 53-4-1004, 53-6-131, and [sections 1 through 9], and to cover the costs of enrollment, including premium assistance, under [section 6(1)], and to pay administrative costs associated with expanded eligibility, and to establish and maintain a reserve; and

(b) may be used only to match federal funds available under the children's health insurance program and the Montana medicaid program.

(3) The unexpended balance of an appropriation from the account must remain in the account and may be used only for the purposes stated in subsection (2).

(4) The special revenue account does not affect and is not exclusive of any other sources of funding for the programs described in [section 4(2)], including the special revenue account provided for in 53-4-1012.

(5) If the department determines that there is insufficient funding for the purposes of subsection (2), it may reduce eligibility requirements for participants in the children's health insurance program as provided in 53-4-1004(4).

Section 10. Section 33-2-708

"33-2-708. Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of \$1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, \$100;

(B) biennial renewal of license, \$50;

(C) lapsed license reinstatement fee, \$100;

(ii) resident insurance producer's license lapsed license reinstatement fee, \$100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

(C) lapsed license reinstatement fee, \$200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, \$50;

(B) biennial renewal of license, \$100;

- (C) lapsed license reinstatement fee, \$200;
- (vii) resident and nonresident rental car entity producer's license:
 - (A) application for original license, including issuance of license, if issued, \$100;
 - (B) quarterly filing fee, \$25;
- (viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), \$50;
- (ix) 50 cents for each page for copies of documents on file in the commissioner's office.
- (c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.
- (2) (a) The commissioner shall charge a fee of \$75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than \$1,500 to a sponsoring organization submitting courses or programs for review in any biennium.
 - (b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).
- (3) (a) The Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.
 - (b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for [section 9].
 - (c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.
- (4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of \$10 will be refunded."

Section 11. Section 53-4-1004

"53-4-1004. (Temporary) Eligibility for program -- rulemaking. (1) To be considered eligible for the program, a child:

- (a) must be 18 years of age or younger;
- (b) must have a combined family income at or below ~~175%~~ 250% of the federal poverty level or at a lower level determined by the department of public health and human services as provided in subsection (4);
- (c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), for 3 months prior to enrollment in the program or since birth, whichever period is less;

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate or may limit the amount, scope, or duration of specific services provided. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 12. Section 53-6-131

"53-6-131. Eligibility requirements. (1) Medical assistance under the Montana medicaid program may be granted to a person who is determined by the department of public health and human services, in its discretion, to be eligible as follows:

(a) The person receives or is considered to be receiving supplemental security income benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq., and does not have income or resources in excess of the applicable medical assistance limits.

(b) The person would be eligible for assistance under the program described in subsection (1)(a) if that person were to apply for that assistance.

(c) The person is in a medical facility that is a medicaid provider and, but for residence in the facility, the person would be receiving assistance under the program in subsection (1)(a).

(d) The person is under 21 years of age and in foster care under the supervision of the state or was in foster care under the supervision of the state and has been adopted as a child with special needs.

(e) The person meets the nonfinancial criteria of the categories in subsections (1)(a) through (1)(d) and:

(i) the person's income does not exceed the income level specified for federally aided categories of assistance and the person's resources are within the resource standards of the federal supplemental security income program; or

(ii) the person, while having income greater than the medically needy income level specified for federally aided categories of assistance:

(A) has an adjusted income level, after incurring medical expenses, that does not exceed the medically needy income level specified for federally aided categories of assistance or, alternatively, has paid in cash to the department the amount by which the person's income exceeds the medically needy income level specified for federally aided categories of assistance; and

(B) has resources that are within the resource standards of the federal supplemental security income program.

(f) The person is a qualified pregnant woman or child as defined in 42 U.S.C. 1396d(n).

(g) The person is under 19 years of age and lives with a family having a combined income that does not exceed 185% of the federal poverty level. The Department may establish lower income levels to the extent necessary to maximize federal matching funds provided for in [section 4].

(2) The department may establish income and resource limitations. Limitations of income and resources must be within the amounts permitted by federal law for the medicaid program. Any otherwise applicable eligibility resource test prescribed by the department does not apply to enrollees in the healthy Montana kids plan provided for in [section 4].

(3) The Montana medicaid program shall pay, as required by federal law, the premiums necessary for medicaid-eligible persons participating in the medicare program and may, within the discretion of the department, pay all or a portion of the medicare premiums, deductibles, and coinsurance for a qualified medicare-eligible person or for a qualified disabled and working individual, as defined in section 6408(d)(2) of the federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, who:

(a) has income that does not exceed income standards as may be required by the Social Security Act; and

(b) has resources that do not exceed standards that the department determines reasonable for purposes of the program.

(4) The department may pay a medicaid-eligible person's expenses for premiums, coinsurance, and similar costs for health insurance or other available health coverage, as provided in 42 U.S.C. 1396b(a)(1).

(5) In accordance with waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may grant eligibility for basic medicaid benefits as described in 53-6-101 to an individual receiving section 1931 medicaid benefits, as defined in 53-4-602, as the specified caretaker relative of a dependent child under the section 1931 medicaid program. A recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage, as provided in 53-6-101.

(6) The department, under the Montana medicaid program, may provide, if a waiver is not available from the federal government, medicaid and other assistance mandated by Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, and not specifically listed in this part to categories of persons that may be designated by the act for receipt of assistance.

(7) Notwithstanding any other provision of this chapter, medical assistance must be provided to infants and pregnant women whose family income does not exceed 133% of the federal poverty threshold, as provided in 42 U.S.C. 1396a(a)(10)(A)(ii)(IX) and 42 U.S.C. 1396a(l)(2)(A)(i), and whose family resources do not exceed standards that the department determines reasonable for purposes of the program.

(8) Subject to appropriations, the department may cooperate with and make grants to a nonprofit corporation that uses donated funds to provide basic preventive and primary health care medical benefits to children whose families are ineligible for the Montana medicaid program and who are ineligible for any other health care coverage, are under 19 years of age, and are enrolled in school if of school age.

(9) A person described in subsection (7) must be provided continuous eligibility for medical assistance, as authorized in 42 U.S.C. 1396a(e)(5) through a(e)(7).

(10) Full medical assistance under the Montana medicaid program may be granted to an individual during the period in which the individual requires treatment of breast or cervical cancer, or both, or of a precancerous condition of the breast or cervix, if the individual:

(a) has been screened for breast and cervical cancer under the Montana breast and cervical health program funded by the centers for disease control and prevention program established under Title XV of the Public Health Service Act, 42 U.S.C. 300k, or in accordance with federal requirements;

(b) needs treatment for breast or cervical cancer, or both, or a precancerous condition of the breast or cervix;

(c) is not otherwise covered under creditable coverage, as provided by federal law or regulation;

(d) is not eligible for medical assistance under any mandatory categorically needy eligibility group; and

(e) has not attained 65 years of age."

NEW SECTION. Section 13. Codification instruction. [Sections 1 through 9] are intended to be codified as an integral part of Title 53, chapter 4, and the provisions of Title 53, chapter 4, apply to [sections 1 through 9].

NEW SECTION. Section 14. {standard} Contingent termination. (1) [Section 11], amending 53-4-1004, terminates on the date that the director of the department of public health and human services certifies to the governor that the federal government has terminated the program or that the federal funding for the program has been discontinued.

(2) The governor shall transmit a copy of the certification to the code commissioner.

(3) Any excess funds remaining upon the termination of the program must be transferred to the general fund.

New Section. Section 15. {standard} This act is effective upon approval by the electorate